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Remarks of
Congressman Henry A. Waxman
to the

NATIONAL ASSOCIATION OF CHAIN DRUG STORES

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Introduction

As the 100th Congress comes to a close, we are putting the final touches on legislation that will make substantial changes in the health care arena in this country. From the expansion of Medicare programs to AIDS to welfare reform, we have faced many hard battles. Today I'd like to highlight for you some of the bills and provisions I know will concern you most, and let you in on some of the legislative plans we are formulating for next year.

Medicare Catastrophic Prescription Drug Benefit

I have been in Congress since 1974. In my first ten years, discussion of the need to expand Medicare was only a quiet undercurrent.

By the mid-1980's, however, the statistics on out-of-pocket expenditures by Medicare beneficiaries clearly indicated that the promise of 1965 was no longer being kept. Health protection for the elderly was slipping. The cost of uncovered services, like drugs, nursing homes and long hospital stays, were skyrocketing. Even the Reagan Administration, with its budget eye blind to all but defense, could not ignore the imperative to expand Medicare coverage.

The Administration came forward with a proposal for catastrophic hospital and doctor coverage. It was good as far as it went. But it left out coverage of many important services.

It was up to Congress to construct what became the Medicare Catastrophic Coverage Act of 1988. As you now know, one of the new benefits we added was outpatient prescription drugs.

There are two simple and compelling reasons why I proposed the coverage of prescription drugs, and why Congress was supportive of the new benefit. Drugs are essential to good health care and, in the last seven years, they have become extremely expensive.

According to the Congressional Budget Office, five and one-half million beneficiaries spend more than $600 a year on outpatient prescription drugs. Two million beneficiaries spend over $1000 a year. Many of these beneficiaries have low incomes; others are on fixed incomes. Not one of them should be left with no protection against the high cost of essential drugs.

The New Drug Benefit

The new drug benefit is not all that I hoped for. It was scaled back due to concerns over the cost. But it is a substantial improvement. Medicare beneficiaries will be assisted, while helping your pharmacies to better serve your elderly customers.

In order to address cost concerns, we agreed to have the drug benefit phased in. Beginning in January, 1991, outpatient prescription drugs will be covered after a $600 deductible is met, with Medicare paying 50% of the cost.

In 1992, the deductible will increase to $650 with Medicare paying a 60% share. The phase-in will be completed in 1993 with Medicare paying its usual 80% after the deductible is met. For 1993, and each succeeding year, the deductible will be set so that a constant proportion of Medicare beneficiaries are covered, or about 17 percent.

The delay until 1991, the phase-in of the copayment, and large reserves were incorporated to give Congress an opportunity to evaluate the total costs of the benefit before it is fully in place. Because the drug benefit is funded solely by premiums from beneficiaries, many Members feared that unexpected cost overruns would produce major increases in premiums. The three year phase-in, will allow time for mid-course program corrections that should avoid painful premium hikes.

The program will especially help low-income Medicare beneficiaries. State Medicaid programs will cover all premiums, deductibles and coinsurance for Medicare beneficiaries with incomes below 100% of poverty.

Your pharmacies become involved by contracting with Medicare as a "participating pharmacy." As such, you will accept assignment, charge Medicare beneficiaries the same fees as other customers, submit claims electronically, and counsel beneficiaries. Medicare will pay you the lower of your actual charges for the particular drug you dispensed, or the Medicare payment limit for that drug.

As you know, the formulas for establishing the payment limits were the subject of intense and long negotiations. The conferees came very close to accepting an "actual acquisition cost" basis for the payment limits. Fortunately, after the representatives of the National Association of Chain Drug Stores and other pharmacy organizations met with staff, that idea was dropped.

We settled on payment limits tied to actual charges and average wholesale prices. This more desirable approach prevailed, at least in part, because of our assumptions that your industry is price competitive and beneficiaries are price sensitive. So we expect that your actual charges will be reasonable.

This system is more fair to you and will encourage pharmacies

to participate. But like all aspects of this new benefit, the payment limits will be thoroughly scrutinized once Medicare starts paying for drugs.

Generics will be encouraged by Medicare. When generics are available, Medicare will only pay at the generic rate. To avoid this rule, a doctor must write on the prescription that a brand name drug is medically necessary.

Medicaid Drug Payment Policies

When I am with pharmacists, I am often asked whether Medicaid will conform its prescription drug payment policies to these new Medicare rules. I know the question flows from your dissatisfaction with the way Medicaid now operates.

Medicaid is dealing with a fundamentally different situation. Medicaid has no deductible and only minimal co-payments by beneficiaries. Therefore, beneficiaries have no incentive to shop around for a better price.

There is no centralized, electronic billing system in Medicaid that records all purchases to allow for easy auditing. Pharmacies can overcharge more easily.

It is not clear whether the new Medicare system is transferable or desirable for Medicaid. I am sure that federal Medicaid officials are considering the matter. I certainly intend to.

Future of Drug Benefit

The future of the prescription drug benefit is hard to predict because it does not begin until 1991. From this vantage point, though, I think there are three safe predictions.

The Congressional concern with the cost of the prescription drug benefit will continue until it is fully phased-in and the costs are known.

The tremendous variance in the cost estimates of the Congressional Budget Office and the Department of Health and Human Services was a topic of discussion throughout the conference. While Congress assumed CBO was right, some cost reducing features were incorporated just in case the Administration was right. Congress will not rest easily until experience proves us right.

With the drug benefit will come a new awareness and concern with drug prices.

Through many mandated reports, the Department of Health and Human Services will record, analyze and explain the impact on Medicare of drug prices increases, the cost of new, high-priced drugs and increased pharmacy charges.

Through a mandated annual guide for physicians of prescription drug prices, physicians will recognize the financial implications of their choice of drugs, especially when generics are available.

Through regular reports to Congress from OTA and the Secretary of Health and Human Services, Congress will be presented with the facts behind the costs of the drug benefit. No longer will the case be made by irate constituents alone. Price increases will be recorded in readily available Congressional reports, which will become part of Congressional debate, especially when premium increases are perceived to be necessary.

The third safe prediction is that we will enter a new era of inquiry about drug use in the elderly.

Volumes of data will be collected through the electronic billing system. These data will enable us to answer questions about the quantity and type of drugs taken by the elderly and about physician prescribing practices.

It is shocking how little we know about drug use by the elderly. An invaluable windfall from the new benefit, and the electronic billing system, will be the advances in our understanding of drugs and the elderly.

Drug Advertising to Consumers

Medicare is not alone in initiating reimbursement for prescription drugs; and Congress is not alone in worrying about the high cost of prescription drugs. State governments, employers, labor unions, commercial insurers and HMOs are all much more involved in the coverage of prescription drugs than just two to three years ago.

Pharmaceutical companies are responding to the intensified interest in their products and their prices. Unfortunately, one new approach they have chosen is to test the advertising of their prescription drugs directly to consumers on the most powerful medium in America -- television.

This shift in advertising strategy will be expensive for consumers. All companies will be forced to follow. Our experience of the last seven years indicates that pharmaceutical companies rarely absorb new costs; they just raise prices.

A shift to television advertising will be potentially dangerous. Consumers simply are not equipped to act upon the information they will receive. Professional health care training alone prepares an individual to determine when a particular prescription drug is appropriate.

If done at all, television advertising to consumers should inform and promote early diagnosis and treatment. But consumers

lack the necessary expertise to know when a prescription drug should be used. Television advertising for the sake of advertising a product serves no educational purpose. Its sole function is to increase consumer pressure on physicians.

Some argue that "institutional advertising" is OK. They claim it is a public health service for a drug company, or any company, to encourage check-ups for blood pressure or cholesterol or ulcers.

I agree. The problem is that much of the advertising so far goes beyond a public health message.

They have gimmicks they hope the consumer will remember in the doctor's office. From the ad for an ulcer drug, they hope consumers will ask for "the 'TLC' (tender loving care) kit for my stomach." From the ad for an arthritis drug, they hope consumers will ask for "the arthritis drug Mickey Mantle was talking about on TV."

This kind of advertising is not a public service. Prescription drugs are not harmless consumer products. If FDA does not establish firm guidelines that restrain the companies' marketing managers, Congress may have to intervene.

Other Health Issues

In the last few minutes, let me fill you in on some of the other health issues Congress will continue to deal with.

This year, we hope to gain passage of a comprehensive Federal AIDS program that will include funding for AIDS research, counseling and testing, and education programs. The Senate has already overwhelmingly passed their version of the bill, and in the House we are gearing up for final floor action in early September.

Our top priority for next year is increasing accessibility to health care services for both the uninsured and the elderly. As you may already know, I have introduced a minimum health benefits bill that would require employers to provide a basic package of health services to all Americans working more than 17 and a half hours a week. We have held several hearings on the bill this year, and hope that the next administration will provide the leadership to turn this vital concept into reality.

Equally important is a comprehensive long-term care bill that I will introduce when Congress returns after Labor Day. It became painfully clear during the catastrophic care debates this year and last that long term care is a burden that few can shoulder alone. This bill will help the one and a half million Medicare benficiaries living at home who need assistance with the simple tasks of daily life, like bathing and eating. It would also help pay the nursing home costs of nearly 2 million Americans, over half of whom must now pay their bills without any assistance from the government or private insurance.

Closing

These and many other issues are crying out for our attention. The Reagan years have been tough and terrible on health care. Too many people have been neglected for too long. I look forward to the opportunity to work with a new administration that will better support the hard work that you and I do to keep this nation healthy and strong.